Outpatient Surgery Center of Central Florida

Transparency in Health Care

59A-3.256 Price Transparency and Patient Billing.

1. Website.

Each facility shall make available to patients and prospective patients price transparency and patient billing information, on its website, regarding the availability of estimates of costs that may be incurred by the patient, financial assistance, billing practices, and a hyperlink to the Agency's service bundle pricing website. The content on the facility's website shall be reviewed at least every 90 days and updated as needed to maintain timely and accurate information. For the purpose of this rule, service bundles means the reasonably expected facility services and care provided to a patient for a specific treatment, procedure, or diagnosis as posted on the Agency's website. In accordance with section 395.301, F.S., the facility's website must include:

a. A hyperlink to the Agency's pricing website, upon implementation of the same, that provides information on payments made to the facilities for defined service bundles and procedures. The Agency's pricing website is located at: http://pricing.floridahealthfinder.gov

b. A statement informing patients and prospective patients that the service bundle information is a non-personalized estimate of costs that may be incurred by the patient for anticipated services and that actual costs will be based on services actually provided to the patient;

c. A statement informing patients and prospective patients of their right to request a personalized estimate from the facility;

d. A statement informing patients of the facility's financial assistance policy, charity care policy, and collection procedure;

e. A list of names and web addresses of health insurers and health maintenance organizations (HMO) contracted with the facility as a network provider or participating provider;

f. A list of names and contact information of health care practitioners and

medical practice groups contracted to provide services within the facility, grouped by specialty or service; and,

g. A statement informing patients to contact the health care practitioners anticipated to provide services to the patient while in the facility regarding a personalized estimate, billing practices, and participation with the patient's insurance provider or HMO as the practitioners may not participate with the same health insurers or HMO as the facility.

2. Estimate.

The facility shall provide an estimate upon request of the patient, prospective patient, or legal guardian for non-emergency medical services.

A. An estimate or an update to a previous estimate shall be provided within 7 business days from receipt of the request. Unless the patient requests a more personalized estimate, the estimate may be based upon the average payment received for the anticipated service bundle. Every estimate shall include:

ii. A statement informing the requestor to contact their health insurer or HMO for anticipated cost sharing responsibilities;

iii. A statement advising the requestor that the actual cost may exceed the estimate;

iv. The web address of the facility's financial assistance policies, charity care policy, and collection procedures;

v. A description and purpose of any facility fees, if applicable;

vi. A statement that services may be provided by other health care providers who may bill separately;

vii. A statement, including a web address if different from above, that contact information for health care practitioners and medical practice groups that are expected to bill separately is available on the facility's website; and,

viii. A statement advising the requestor that the patient may pay less for the procedure or service at another facility or in another health care setting.

B. If the facility provides a non-personalized estimate, the estimate shall include a statement that a personalized estimate is available upon request.

C. A personalized estimate must include the charges specific to the patient's anticipated services.

3. Itemized statement or bill.

The facility shall provide an itemized statement or bill upon request of the patient or the patient's survivor or legal guardian. The itemized statement or bill shall be provided within 7 business days after the patient's discharge or release, or 7 business days after the request, whichever is later. The itemized statement or bill must include:

a. A description of the individual charges from each department or service area by date, as prescribed in subsection 395.301(1)(d), F.S.;

b. Contact information for health care practitioners or medical practice groups that are expected to bill separately based on services provided; and,

c. The facility's contact information for billing questions and disputes.

Rulemaking Authority 395.301 FS. Law Implemented 395.301 FS. History–New 2-19-18.